Kansas Health Homes Proposal

The Kansas health home initiative began with the KanCare Request for Proposal (RFP) in which health homes were included as a requirement for the KanCare managed care organizations (MCOs). An interagency project team was formed, including staff from the former Kansas Department on Aging (KDOA) and Social and Rehabilitation Services (SRS) – now combined into Kansas Department on Aging and Disability Services (KDADS), along with Kansas Department of Health and Environment (KDHE) staff. Prior to KanCare implementation, much of the project team's work was exploratory; however, a timeline was developed and significant research was done, including talking with other states that had recently implemented health homes, working with the federal technical assistance contractor (Center for Health Care Strategies – CHCS) and applying for federal planning money, which was approved on August 30, 2012.

In the summer of 2012, a stakeholder group was formed, the Health Homes Focus Group, to first help educate provider groups about the health homes initiative and then to gain input from the group. The Focus Group is comprised of over 70 members who represent various provider groups, health care foundations, provider associations, and public health partners and meets every two months.

Ongoing efforts are occurring to help educate and engage stakeholders in this initiative, including, most recently, a Health Homes Forum held in April 2013. A health homes web page has been launched and is located here: http://www.kancare.ks.gov/health_home.htm . This web page, and the e-mail box located on it, will be used to obtain input from a wider stakeholder audience about draft materials related to the initiative.

Implementation of health homes in KanCare will begin January 2014, for persons with serious mental illness. Additional target groups will follow closely, including individuals with chronic conditions such as diabetes.

Necessary Components

In order to provide the health homes option within a Medicaid program, states must submit a Medicaid State Plan Amendment (SPA) to the Centers for Medicare and Medicaid Services (CMS). That SPA must define the target population(s) for whom health homes will be provided, as well as describe the model the state will use. In addition, the state must further define six core services that are required. Those core services are:

- Comprehensive care management
- Care coordination and health promotion
- Comprehensive transitional care from inpatient to other settings, including appropriate follow-up
- Individual and family support
- Referral to community and social supports
- Use of HIT to link services

Provider qualifications, quality goals and measures, and payment methodology must also be defined in the SPA. The Project Team is proceeding with this work through sub-groups that report to the Project Team and the Focus Group.

Proposed Model

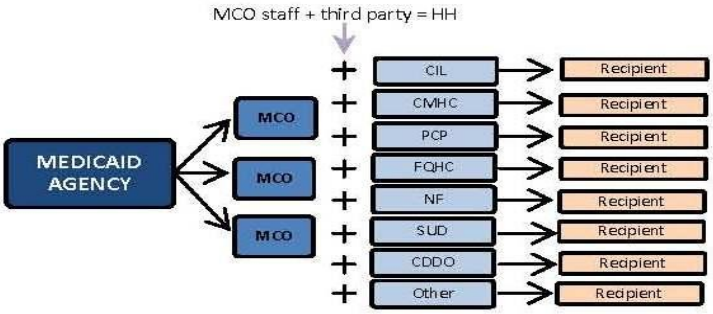
The State selected the second of the three model options offered in the State Medicaid Directors Letter and described below.

1. A designated provider: May be a physician, clinical/group practice, rural health clinic, community health center, community mental health center, home health agency, pediatrician, OB/GYN, other

2. A team of health professionals: May include physician, nurse care coordinator, nutritionist, social worker, behavioral health professional, and can be free standing, virtual, hospital-based, community mental health centers, etc.

3. A health team: Must include medical specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral health providers, chiropractics, licensed complementary and alternative medicine practitioners and physicians' assistants

We expect a partnership between the managed care organization (MCO) and another entity (Health Home Partner) that is appropriate for the consumer as in this diagram, modified from a similar one published by the Center for Health Care Strategies in the brief *Implementing Health Homes in a Risk-Based Medicaid Managed Care Delivery System* by Dianne Hasselman and Deborah Bachrach (June 2011):



This model appears to offer the greatest flexibility for providing health home services within a capitated, fully risk-based managed care delivery system. Such flexibility will be important since Kansas is a largely rural state, with a few well-defined urban areas, and familiar community providers, such as community mental health centers are important. In addition, health home recipients will likely have experience with, and preferences for, different types of providers depending upon where they live and what Medicaid population sub-group they belong to.

Kansas Medicaid consumers who are served in the KanCare managed care program, and who would be eligible for health homes, are likely to have strong relationships with community providers such as:

- Centers for Independent Living (CIL)
- Community Mental Health Centers (CMHC)

- Community Developmental Disability Organizations (CDDO)
- Federally Qualified Health Centers (FQHC) and other safety net clinics
- Primary Care Providers (PCP)
- Substance Use Disorder (SUD) provider

These providers could be Health Home Partners with the MCOs, assuming they meet the provider qualifications, can provide some of the six core services and are willing to contract with the MCOs.

Target Groups

Kansas wants to initially begin health homes coverage with persons who have serious mental illness. The design of the community mental health system in Kansas lends itself to the health homes model selected by the State, and appear to be best prepared to implement this model, in partnership with MCOs, by January 2014.

The State also plans to cover groups with chronic conditions like diabetes, but wants to make sure health homes for those groups are ready to implement upon federal approval.

The State believes it is important to include people with diabetes early in health homes because the prevalence of diabetes among adult fee for service Medicaid beneficiaries in 2011 (pre-KanCare) was 20.5% (N=37,577) and the net payment by Kansas Medicaid for all services for those beneficiaries was $559,307,804 (36.1% of total expenses), amounting to $14,884/person.

The State will employ an “opt-out” enrollment methodology whereby consumers will be placed into health homes automatically when they meet the pre-specified criteria. CMS requires that all consumers eligible for health homes have a choice of provider. The Health Home Partner will be selected for consumers based upon previous service utilization and provider relationship. They will receive a letter explaining this placement with instructions on how to opt out of the placement and may request a different Health Home Partner at that time. Consumers will then remain in their health homes for a year, but have an annual opportunity to change health homes, just as they can annually change MCOs. There will be a specific grievance and appeal process for health homes.

State partners at the University of Kansas will help refine the definition of the specific target groups, as well as help determine quality measures.

Goals

The State has proposed the following goals for health homes and is currently working on development of the quality measures:

1. Reduce utilization associated with avoidable (preventable) inpatient stays
2. Improve management of chronic conditions
3. Improve care coordination
4. Improve transitions of care between primary care providers and inpatient facilities

CMS will soon require states to collect data for eight core measures, so these are also included in the quality measures the State will collect and report.

Services

The State anticipates that some health home services would be provided by the MCOs and some by the Health Home Partner. Some services may be jointly provided by the two. For example, *care coordination* would likely be the responsibility of the MCOs since they already have this capacity. The KanCare contract requires MCOs to provide similar services to a significant portion of the KanCare population, including to all members who receive long-term supports and services, with some face-to-face requirements. In addition, the MCOs have sophisticated data systems that will assist in identification of potential health home members and be able to collect and report critical quality metrics. Alternatively, *patient and family support* would likely be provided by the community health home partner since the agencies listed above have both history and expertise in this area and consumers are accustomed to turning to these agencies for such help.

Payment

The State's proposal for payment is to include payment for health home services in the existing per member per month (PMPM) payment the state makes to the MCOs. This payment would be an add-on to the existing PMPM payment, or a specific PMPM payment, for the target populations receiving health home services. The MCOs could then make various payment arrangements with their health home partners. The State's actuaries will work to help define the payment amount, ensuring that it is actuarially sound and sustainable.

The State understands that health homes funding cannot duplicate existing funding for targeted case management or for already existing care management provided by the MCOs. Ensuring that no duplication occurs will be accomplished through service definitions and payment structure. In addition State program integrity and quality assurance processes will also be applied.

Other Issues

The State has not yet worked out with the MCOs how they will share information with the health home partners or what the reporting requirements to the State will be. Clarification is needed about whether or not CMS expects reporting specific to each health home partner or whether reporting can be at the MCO level. Also to be determined is whether CMS expects consumer-level reporting or only aggregate reporting by target group condition.

Provider qualifications are still being formulated, but health home partners will not be required to seek accreditation from any national organization. Since Kansas requires all KanCare MCOs to be NCQA-accredited by June 2014, the State believes that will be sufficient and will not require the health home partners to be accredited.